

Date:		HEALTH
Health Care Provider Information Name (First, Last): Practice Phone #: Practice Address:		
Patient Info Name (First,	rmation Last):	Age: Race age (in weeks)
Address:		Phone #:
Travel and Potential Flavivirus Exposure		
I would like to ask you about if you might have been exposed to Zika virus or related viruses before.		
Did you trav	el outside the United	States (or to a US territory: Puerto Rico, USVI, Am Samoa) in the <u>last two weeks</u> ?
□ Yes		st six months? \(\text{Yes} \) \(\text{No} \)
		
		:/End date:/
	• • • • • • • • • • • • • • • • • • • •	:/End date:/
Dat	es of travel: Start date	:/End date:/
Medical Information		
[In the past	month], have you had	d any of these symptoms? New for you, not long standing problems.
Fever	☐ Yes ☐ No	
	bjective fever is accept	
Rash	☐ Yes ☐ No	
(NOT askina	about localized rash	Was the rash itchy? ☐ Yes ☐ No
(NOT asking about localized rash or secondary to topical exposures) Conjunctivitis (not allergic type) □ Yes □ No		
3	g. Jr.	If yes, first date with this/ How many days did it last?
Joint Pain	□ Yes □ N	
	c or post-trauma pain	
For this illness, did you go to a clinic/hospital to be checked? Yes No If yes, what did the doctor/nurse decide that you had?		
Other expos	ures	
In the last month, have you had sex with someone who had recently returned from a country where Zika has been spreading? (By recently returned, we mean your partner had returned sometime during the 2 months <i>before</i> the time you had sex)		
Your Answe	r □ Yes	□ No □ Unknown If yes, gestational age (in weeks)
For females:	Are you pregnant or t	hink you might be pregnant?
□ Yes	□ No	□ Unknown